

MEDICAL REVIEW – SOUTHERN SECTION V
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

**AIDS HEALTHCARE FOUNDATION
DBA POSITIVE HEALTHCARE**

Contract Number: 11-88286

Audit Period: October 1, 2017
Through
September 30, 2018

Report Issued: May 22, 2019

TABLE OF CONTENTS

I.	INTRODUCTION	1
II.	EXECUTIVE SUMMARY	2
III.	SCOPE/AUDIT PROCEDURES	5
IV.	COMPLIANCE AUDIT FINDINGS	
	Category 1 – Utilization Management.....	6
	Category 3 – Access and Availability of Care	15
	Category 4 – Member Rights	17
	Category 5 – Quality Management	24

I. INTRODUCTION

AIDS Healthcare Foundation, founded in 1987, is a not-for-profit organization providing Human Immunodeficiency Virus (HIV) treatment to more than 1,000,000 patients in 43 countries. AIDS Healthcare Foundation dba Positive Healthcare (Plan) provides health care for Medi-Cal recipients in Los Angeles County.

Positive Healthcare was established in California in 1995, under a Federal Waiver from the Department of Health and Human Services. The Department of Health Care Services (DHCS) entered into an agreement with AIDS Healthcare Foundation dba Positive Healthcare in 2012. The Plan expanded services to Florida in 2008, and to Georgia in 2018. Positive Healthcare currently provides care to more than 4,200 people in California, Florida, and Georgia.

The Plan delivers care to eligible beneficiaries who reside within their service area and are at least 21 years old with an Acquired Immune Deficiency Syndrome (AIDS) diagnosis.

The Plan provides health care designed around the needs of people living with all stages of AIDS. The Plan covers physician services from doctors who are HIV specialists, hospital outpatient department services, laboratory and X-ray services, pharmaceutical services and prescribed drugs, skilled nursing facility care, preventive health care services, and mental health.

The Plan had a total average membership of 669 members for its Medi-Cal line of business for the audit period under review.

II. EXECUTIVE SUMMARY

This report represents the findings of the Department of Health Care Services (DHCS) medical review audit, for the period of October 1, 2017 through September 30, 2018. The onsite review was conducted from January 22, 2019 through January 31, 2019. The audit consists of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on April 24, 2019 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. On May 9, 2019 the Plan submitted a response after the exit conference. The results of our evaluation of the Plan's response are reflected in this report.

The audit evaluated four categories of performance: Utilization Management, Access and Availability of Care, Member Rights, Quality Management.

The prior DHCS medical audit (for the period October 1, 2016 through September 30, 2017) was issued on June 11, 2018. This audit examined documentation for compliance and to determine to what extent the Plan has operationalized their corrective action plan (CAP). The prior year CAP was closed as of September 28, 2018. A finding denoted as a repeat finding is an uncorrected deficiency substantially similar to that identified in the previous audit.

Category 1 – Utilization Management

The audit revealed deficiencies in the Plan's Utilization Management program. The Plan is required to send a written Notice of Action letter to a beneficiary when their medical service has been denied, deferred, or modified. The Plan's Notice of Action letters did not include a description of the criteria or guidelines used for the denial of pharmaceutical requests as required in All Plan Letter (APL) 17-006 and Health and Safety Code, Section 1367.01(h)(4), Title 22, CCR, Sections 51014.1(c)(3) and 53894(d)(3). The Plan did not have a process in place to ensure that the Notice of Action letters contained all the required elements for the explanation of the denial, including a description of the criteria or guidelines that supported their decision.

APL 13-018 outlines the Plan's obligation to conduct a mental health assessment for beneficiaries with a potential mental health condition using a tool mutually agreed upon with the Local Mental Health Agency, as required by Title 9, CCR, Section 1850.505. The Plan did not use a mutually agreed upon assessment tool because they have not reached an agreement.

The Plan's policies and procedures were not consistent with the APL 17-018 requirement to provide initial mental health assessments by a licensed mental health provider without a referral or prior authorization, as required by Title 42, CFR, Section

438.930. The Plan beneficiaries may seek and obtain a mental health assessment at any time directly from a licensed mental health provider within the Plan's network without a referral from a primary care provider or prior authorization from the Plan. The Plan's Policy and Procedures did not clearly define an initial mental health assessment as a self-referred service.

Medi-Cal managed care health plans are responsible to cover and pay for an expanded alcohol screening for members 18 years of age and older who answer "yes" to the alcohol question in the Staying Healthy Assessment, or at any time the primary care provider identifies a potential alcohol misuse problem. The Plan's Evidence of Coverage/Membership Guide did not accurately inform members' of their right to receive Screening, Brief Intervention, and Referral to Treatment (SBIRT) services as required in APL 14-004 and recommended by the United States Preventive Services Task Force (USPSTF).

Category 3 – Access and Availability of Care

The Contract states the Plan shall provide each member with a Provider Directory, which includes the name, National Provider Identifier (NPI) number, address, and telephone number of each service location, and the hours and days when each facility is open. The required provider information elements were not available to members in the Plan's printed and web portal Provider Directory. The Plan did not have a process in place to assure that the provider data available to members was complete and accurate.

Category 4 – Member's Rights

The Plan is required to maintain a member Grievance System. The Contract states Grievances related to medical quality of care issues shall be referred to the Contractor's Medical Director. There was no documentation that the Plan's Medical Director, or a health care professional with clinical expertise in treating a beneficiary's condition or disease, was resolving Grievances related to medical quality of care. The Plan did not forward all Grievances related to medical quality of care to the medical director or designee for action. The Plan was unaware that the Grievance files must contain direct evidence of the Medical Director's involvement in the resolution of the quality of care Grievances. The Plan did not have a process in place to ensure that all Grievances regarding medical quality of care were referred to the Plan's Medical Director or his designee for resolution.

The Plan was misclassifying Grievances as inquiries. A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination as stated in APL 17-006 and Title 42, CFR Section 438.400(b). The Plan's definition of an inquiry does not state that any expression of dissatisfaction shall be considered a Grievance. The Plan was unable to distinguish between Grievances and inquiries, as required by Title 28, CCR Sections 1300.68(a)(1) and (2), and did not report all Grievances received

during the audit period. Among the five inquiry files reviewed, only one was actually an inquiry.

Medi-Cal managed care health plans are required to post nondiscrimination notice requirements and language assistance taglines in significant communications to beneficiaries as stated in APL 17-006. Plan members were not informed about their right to nondiscrimination and language assistance, as required by Title 45, CFR, Section 92.8. The “Nondiscrimination Notice” and “Language Assistance” taglines were not supplied with the Grievance acknowledgment letters and the Grievance resolution letters during the audit period.

The Plan is required to maintain, and have available for DHCS review, Grievance logs, including copies of Grievance logs of any sub-contracting entity delegated the responsibility to maintain and resolve Grievances. The Plan’s Grievance log was missing required reporting information. The Plan’s Grievance log did not meet the standards set by APL 17-006. The Plan’s Grievance log was missing the time of receipt of the Grievance, the name of the representative recording the Grievance, and the name of the Medi-Cal Managed Care Plan provider or staff responsible for resolving the Grievance, as required by Title 22, CCR, Section 53858(e)(1) and Title 28, CCR, Section 1300.68(b)(5).

Category 5 – Quality Management

The Plan is required to ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. The Plan did not meet the requirement to provide training within ten (10) working days after the Plan places a newly contracted provider on active status. The Plan’s staff were conducting new provider orientations and trainings outside the required timeline.

The Plan shall ensure that provider training includes information on all Member Rights specified in the Contract, including the right to full disclosure of health care information and the right to actively participate in health care decisions. Member Rights were not included in new provider training. The verification study disclosed that the Provider Orientation Summary did not include Member Rights as a topic of discussion. Furthermore, the orientation materials did not include Member Rights in any of the orientation materials.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS) Medical Review Branch to ascertain that medical services provided to the Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the Primary Care Case Management Contract.

PROCEDURE

DHCS conducted an on-site audit of the Plan from January 22, 2019 through January 31, 2019. The audit included a review of the Plan's Contract with DHCS, its policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Request: 10 medical prior authorizations and eight pharmacy prior authorizations were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

No Appeal cases were reported for the audit period under review because there were no prior authorization denials of medical requests and just a few denials for pharmacy.

Category 3 – Access and Availability of Care

Emergency Service Claims: Six emergency service claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 19 Grievances (8 Quality of Care and 11 Quality of Service) and five inquiries were reviewed for timely resolution, response to complainant, and submission to appropriate level for review.

Category 5 – Quality Management

Provider Training: Seven new provider-training records were reviewed for timely provision of Medi-Cal Managed Care program training.

A description of the findings for each category is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare

AUDIT PERIOD: October 1, 2017 through September 30, 2018

DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

CATEGORY 1 - UTILIZATION MANAGEMENT

1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures:

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

- A. Qualified health care professionals supervise review decisions, including service reductions, and a qualified Physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this provision, the review of the denial of a pharmacy prior authorization may be by a qualified Physician or Contractor's Pharmacist.
- B. There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.
- C. Reasons for decisions are clearly documented.
- D. Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.
- F. Decisions and Appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.
- H. Records, including any Notice of Action, shall meet the retention requirements described in Exhibit E, Attachment 2, provision 19.
- I. Contractor must notify the requesting provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing.

PCCM Contract A.5.2.A, B, C, D, F, H, I

Exceptions to Prior Authorization:

Prior Authorization requirements shall not be applied to Emergency Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

PCCM Contract A.5.2.G

Timeframes for Medical Authorization:

Pharmaceuticals: 24 hours on all drugs that require prior authorization in accordance with...

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare

AUDIT PERIOD: October 1, 2017 through September 30, 2018

DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

...Welfare and Institutions Code, Section 14185 or any future amendments thereto.
PCCM Contract A.5.3.F

Routine authorizations: Five (5) Working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health & Safety Code, Section 1367.01, or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
PCCM Contract A.5.3.G

Denial, Deferral, or Modification of Prior Authorization Requests:

Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative... This notification must be provided as specified in Title 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.
PCCM Contract A.13.8.A

ALL PLAN LETTER 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments

MCPs shall comply with all other existing state laws and regulations in determining whether to approve, modify, or deny requests by providers prospectively, concurrently, or retrospectively. For decisions based in whole or in part on medical necessity, the written Notice of Action shall contain all of the following... A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guideline...

References Cited:

Title 22, CCR, Section 51014.1, Fair Hearing Related to Denial, Termination or Reduction in Medical Services
Title 22, CCR, Section 51014.2, Medical Assistance Pending Fair Hearing Decision
Title 22, CCR, Section 53894, Notice to Members of Plan Action to Deny, Defer or Modify a Request for Medical

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: AIDS Healthcare Foundation dba Positive Healthcare
AUDIT PERIOD: October 1, 2017 through September 30, 2018
DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

SUMMARY OF FINDINGS:

1.2.1 Notice of Action Letters for Denial of Pharmaceutical Requests

All Plan Letter (APL) 17-006 states that for decisions based in whole or part on medical necessity, the written Notice of Action letters shall contain...a description of the criteria or guidelines used. This includes a reference to specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guideline, as required by Health and Safety Code, Section 1367.01(h)(4), Title 22, CCR, Sections 51014.1(c)(3) and 53894(d)(3).

The Plan's Policy and Procedure PH 10.3, Coverage Determination and Redetermination for Drugs and Therapeutic Devices states that "if the Plan denies, in whole or in part, a request for a benefit, or payment for a prescription drug purchased by an enrollee, it must provide...a description of any applicable coverage rule or any other applicable Plan policy upon which the denial decision was based, including any specific formulary criteria that must be satisfied for approval."

The Notice of Action letters did not include a description of the criteria or guidelines used for the denial of pharmaceutical requests. The verification study showed evidence that the Plan did not adhere to their own policy and procedure. Five of the eight Notice of Action letters' reviewed did not include a description of the criteria or guidelines used.

The Plan did not have a process in place to ensure that the Notice of Action letters contained all the required elements for the explanation of the denial, including a description of the criteria or guidelines that support their decision. The Plan explained that this was due to staff error.

Five members received incomplete denial notification. If the members receive incomplete denial notifications, this can affect their ability to file a meaningful Appeal and it can slow down the Appeal process.

RECOMMENDATIONS:

1.2.1 Establish a process to ensure policy adherence to APL-17-006 so that Notice of Action letters contain a description of the criteria or guidelines used for the explanation of the denials.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare

AUDIT PERIOD: October 1, 2017 through September 30, 2018

DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

1.4

MENTAL HEALTH AND SUBSTANCE ABUSE

Mental Health and Substance Use Disorder Services:

The Plan shall cover outpatient mental health services that are within the scope of practice of Primary Care Physicians. The Plan's policies and procedures shall define and describe what services are to be provided by Primary Care Physicians.

In addition, the Plan shall cover and ensure the provision of psychotherapeutic drugs prescribed by its Primary Care Providers, except those specifically excluded in the Contract.

The Plan shall develop and implement a written internal policy and procedure to ensure that Members who need Specialty Mental Health Services (services outside the scope of practice of Primary Care Physicians) are referred to and are provided mental health services by an appropriate Medi-Cal FFS mental health Provider or to the local mental health plan for specialty mental health services.

The Plan shall establish and maintain mechanisms to identify Members who require non-covered psychiatric services and ensure appropriate referrals are made. The Plan shall continue to cover and ensure the provision of primary care and other services unrelated to the mental health treatment and coordinate services between the Primary Care Provider and the psychiatric service Provider(s). The Plan shall enter into a Memorandum of Understanding with the county mental health plan.

PCCM Contract A.10.6.D.4

Parity in mental health and substance use disorder benefits:

Each MCO, PIHP and PAHP providing services to MCO enrollees in a State that covers both medical/surgical benefits and mental health or substance use disorder benefits under the State plan, must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees.

A MCO, PIHP, or PAHP may not impose a nonquantitative treatment limitation for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the MCO, PIHP, or PAHP as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification...

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare

AUDIT PERIOD: October 1, 2017 through September 30, 2018

DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

1.4

MENTAL HEALTH AND SUBSTANCE ABUSE

... are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in apply the limitation for medical/surgical benefits in the classification.

Any MCO, PIHP or PAHP providing access to out-of-network providers for medical/surgical benefits within a classification, must use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits.

CFR, Title 42, Section 438(n)(subpart K)

All Plan Letter 18-015: Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans

Each Medi-Cal managed care health plan (MCP) is obligated to conduct a mental health assessment for members with a potential mental health condition using a tool mutually agreed upon with the Mental Health Plan (MHP) to determine the appropriate care needed.

ALL PLAN LETTER 13-018: Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans

Each Medi-Cal managed care health plan is obligated to conduct a mental health assessment for beneficiaries with a potential mental health condition using a tool mutually agreed upon with the Mental Health Plan to determine the appropriate care needed.

ALL PLAN LETTER 17-018: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services

MCPs must be in compliance with Mental Health Parity requirements on October 1, 2017, as required by Title 42, CFR, Section 438.930. MCPs shall also ensure direct access to an initial mental health assessment by a licensed mental health provider within the MCP's provider network. MCPs shall not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. MCPs shall notify beneficiaries of this policy, and MCPs informing materials must clearly state that referral and prior authorization are not required for a beneficiary to seek an initial mental health assessment from a network mental health provider.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare

AUDIT PERIOD: October 1, 2017 through September 30, 2018

DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

1.4

MENTAL HEALTH AND SUBSTANCE ABUSE

ALL PLAN LETTER 14-004: Screening, Brief Intervention, and Referral to Treatment for Misuse of Alcohol

Medi-Cal managed care health plans shall include Screening, Brief Intervention, and Referral to Treatment (SBIRT) services in their member-informing materials and their procedures that address Grievances and Appeals regarding SBIRT services, as recommended by the United States Preventive Services Task Force (USPSTF).

Policy and All Plan Letters means a document that has been dated, numbered, and issued by the Medi-Cal Managed Care Division, and provides clarification of Contractor's obligations pursuant to this Contract, and clarifies mandated changes in State or Federal statutes or regulations...

PCCM Contract E.1.75

All existing final Policy Letters issued by MMCD are hereby incorporated into this Contract and shall be complied with by Contractor. All Policy Letters issued by MMCD subsequent to the effective date of this Contract shall provide clarification of Contractors obligations pursuant to this Contract, and may include instructions to the Contractor regarding implementation of mandated obligations pursuant to changes in State or federal statutes or regulations, or pursuant to judicial interpretation.

PCCM Contract E.2.1.D

References Cited:

Title 22 CCR Section 51014.2 – Medical Assistance Pending Fair Hearing Decision

Title 22 CCR Section 53858 – Member Grievance Procedures

Title 28 CCR Section 1300.68 – Grievance System

Title 28 CCR Section 1300.68.01 – Expedited Review of Grievances

42 CFR 438.406 – Handling of Grievances and Appeals

42 CFR 438.420(a)(b) and (c) – Continuation of Benefits while the MCO or PIHP Appeal and the State Fair Hearing are Pending.

42 CFR 438.900-930 –Parity in Mental Health and Substance Use Disorder Benefits

SUMMARY OF FINDINGS:

1.4.1 Mental Health Assessment Tool

All Plan Letters (APL) 13-018 and APL 18-015 states that each Medi-Cal managed care health plan (MCP) is obligated to conduct a mental health assessment for beneficiaries with potential mental health condition using a tool mutually agreed upon with the county Mental Health Plan

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: AIDS Healthcare Foundation dba Positive Healthcare
AUDIT PERIOD: October 1, 2017 through September 30, 2018
DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

(MHP), to determine the appropriate care needed, as required by Title 9, CCR, Section 1850.505.

The Plan's Policy and Procedure CM 42.3, PHC Mental Health Services states that "the Plan is responsible for maintaining appropriate memorandum of understanding with mental health providers to execute the necessary mental services as described in the Contract. The memorandum of understanding should be the primary mechanism for ensuring beneficiary access to medically necessary mental health services."

The Plan disclosed that they did not use a mutually agreed upon mental health assessment tool with the Los Angeles County Department of Mental Health. The Plan did not implement APL 13-018 requirements. The Plan stated it has not reached an agreement with the Local Mental Health Agency to use an assessment tool for the initial mental health screening.

Failure to provide a uniform mental health assessment tool creates poor disease management for members with the possibility of complications.

1.4.2 Member's Right to Initial Mental Health Assessment

The Plan's Contract states that "Contractor shall establish and maintain mechanisms to identify Members who require non-covered psychiatric services and ensure appropriate referrals are made."

PCCM Contract A.10.6.D.4

The Plan's Contract further states that "Policy and All Plan Letters means a document that has been dated, numbered, and issued by the Medi-Cal Managed Care Division, and provides clarification of Contractor's obligations pursuant to this Contract, and clarifies mandated changes in State and Federal statutes or regulations."

PCCM Contract E.1.75

All Plan Letter (APL) 17-018 states that "MCPs must be in compliance with Mental Health Parity requirements on October 1, 2017, as required by Title 42, CFR, Section, 438.930. MCPs shall also ensure direct access to an initial mental health assessment by a licensed mental health provider within the MCP's provider network. MCPs shall not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. MCPs shall notify beneficiaries of this policy, and MCPs informing materials must clearly state that referral and prior authorization are not required for a beneficiary to seek an initial mental health assessment from a network mental health provider."

The Plan's Policy and Procedure UM 21.1, PHC Access to Self-Referred Covered Services did not address mental health as one of the self-referred services.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare

AUDIT PERIOD: October 1, 2017 through September 30, 2018

DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

The Plan's Policy and Procedure CM 42.3, PHC Mental Health Services states that "at any time, members can opt to seek and obtain a mental health assessment from a licensed mental health provider within the plan's contracted network...The plan requires its primary care provider network to conduct mental health screenings of its members...Primary care providers will further assess members who screen positive or refer them accordingly to network licensed mental health providers."

The Plan did not implement APL 17-018 requirements. The Plan's policies and procedures were inconsistent with the requirement to provide initial mental health assessments by a licensed mental health provider without a referral or prior authorization.

Not having clear policies and procedures to access initial mental health screening by a licensed mental health provider can delay the members' diagnosis and treatment.

1.4.3 Membership Guide Information on Member's Right to an Initial Mental Health Assessment

The Plan's Contract states that "Contractor shall establish and maintain mechanisms to identify Members who require non-covered psychiatric services and ensure appropriate referrals are made."

PCCM Contract A.10.6.D.4

The Plan's Contract further states that "Policy and All Plan Letters means a document that has been dated, numbered, and issued by the Medi-Cal Managed Care Division, and provides clarification of Contractor's obligations pursuant to this Contract, and clarifies mandated changes in State and Federal statutes or regulations."

PCCM Contract E.1.75

All Plan Letter (APL) 17-018 states that "MCPs must be in compliance with Mental Health Parity requirements on October 1, 2017, as required by Title 42, CFR, Section 438.930. MCPs shall also ensure direct access to an initial mental health assessment by a licensed mental health provider within the MCP's provider network. MCPs shall not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. MCPs shall notify beneficiaries of this policy, and MCPs informing materials must clearly state that referral and prior authorization are not required for a beneficiary to seek an initial mental health assessment from a network mental health provider."

The Plan's Membership Guide states that "the Plan has a memorandum of understanding in place with the Los Angeles County Department of Mental Health to accept referrals from the Plan for mental health services. Should a member need these services, the Plan will refer the member to local Department of Mental Health providers."

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: AIDS Healthcare Foundation dba Positive Healthcare
AUDIT PERIOD: October 1, 2017 through September 30, 2018
DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

The Plan did not inform members of their right for an initial mental health assessment without a referral from a primary care provider. The Plan wrongfully presents information to its members in the Evidence of Coverage/Membership Guide.

The Plan's Evidence of Coverage/Membership Guide was not up-to-date. The Evidence of Coverage/Membership Guide was last updated on July 1, 2012.

Without information, Members are least likely to ask for proper screening, causing condition of possible misdiagnosis and exacerbation of symptoms.

1.4.4 Screening, Brief Intervention, and Referral to Treatment (SBRT) Services

All Plan Letter (APL) 14-004 states Medi-Cal managed care health plans shall include Screening, Brief Intervention, and Referral to Treatment (SBIRT) services in their member informing materials and their procedures that address Grievances and Appeals regarding SBIRT services, as recommended by the United States Preventive Services Task Force (USPSTF).

The Plan's Evidence of Coverage/Membership Guide did not inform members about their right to SBIRT services.

The Membership Guide has not been updated since July 2012. Without accurate Membership Guide information, members are less likely to request services.

Members being misled about available services will not ask for assistance, possibly resulting in deterioration of physical and mental state.

RECOMMENDATIONS:

1.4.1 Develop a mutually agreed upon mental health assessment tool with the local County Department of Mental Health.

1.4.2 Update and include mental health initial screening as a self-referred service in the Policy and Procedures.

1.4.3 Update Membership materials to include that the initial mental health assessment is available without a referral from a primary care provider.

1.4.4 Update Membership materials to include the availability of Screening, Brief Intervention, and Referral to Treatment for misuse of alcohol.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare

AUDIT PERIOD: October 1, 2017 through September 30, 2018

DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1

APPOINTMENT PROCEDURES AND WAITING TIMES

Appointment Procedures:

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

PCCM Contract A.9.3.A

Members must be offered appointments within the following timeframes:

3) Non-urgent primary care appointments – within ten (10) business days of request;

4) Appointment with a specialist – within fifteen (15) business days of request;

PCCM Contract A.9.4.B

Prenatal Care:

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.

PCCM Contract A.9.3.B

Monitoring of Waiting Times:

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in subparagraph A, Appointments, above.

PCCM Contract A.9.3.C; See Appointment Procedures above, Contract A.9.3.A

Provider Directory:

Contract requires the provider directory to include the name, National Provider Identifier (NPI) number, address and telephone number of each service location, and the hours and days when each facility is open.

PCCM Contract A.13.4.D.4

SUMMARY OF FINDINGS:

3.1.1 Provider Directory

The Contract states that the Plan shall provide each member with a Provider Directory, which includes the name, National Provider Identifier (NPI) number, address, and telephone number of each service location, and the hours and days when each facility is open.

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: AIDS Healthcare Foundation dba Positive Healthcare
AUDIT PERIOD: October 1, 2017 through September 30, 2018
DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

The Plan's Policy and Procedure MS 10.1, Provider and Pharmacy Directory states that "the Plan shall develop and produce a provider and pharmacy directory publication that includes the name, NPI number, address, phone number, hours and days when each service location is open, including pharmacy. The policy further states that the Plan shall update its online provider directory information weekly and paper directory monthly. The Plan shall post the updated paper directory to its website in a downloadable file format (PDF) monthly concurrent with update."

In response to the prior year CAP report, the Plan partially revised their printed provider directory. The Plan revised their provider directory template, and their provider data collection and validation was expected to be completed by October 31, 2018, for the online directory, however it was not completely corrected due to the partial revisions.

The printed Provider Directory and the provider data information accessible via the Plan's web portal were not accurate due to one or more of the required elements not available to members. The days and hours of operation of providers within Behavioral Health and Pharmacy networks were not listed in the online and printed directory. Furthermore, the printed Provider Directory listings of the Pharmacy network did not include NPI number information.

In response to this deficiency, the Plan submitted Policy and Procedure MS 10.1, which was effective July 1, 2018, but was reviewed and revised on February 4, 2019, after the onsite review period. The available provider information to members through the printed directory was inconsistent with the Plan's provider search online tool. The Plan did not have a process in place to assure that provider data available to members was correct.

When the provider information available to members is inaccurate, this limits the member's ability to make an informed choice of provider in obtaining care.

This is a repeat finding.

RECOMMENDATIONS:

3.1.1 Monitor and continue to update the printed and online Provider Directory for accuracy.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare

AUDIT PERIOD: October 1, 2017 through September 30, 2018

DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

CATEGORY 4 – MEMBER’S RIGHTS

4.1

GRIEVANCE SYSTEM

Member Grievance System:

Contractor shall implement and maintain a Member Grievance system in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22, CCR, Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D, item 12), and 42 CFR 438.420(a)-(c). Contractor shall resolve each Grievance and provide notice to the Member as quickly as the Member’s health condition requires, within 30 calendar days from the date Contractor receives the Grievance. Contractor shall notify the Member of the Grievance resolution in a written member notice.

PCCM Contract A.14.1

Grievance System Oversight:

Contractor shall implement and maintain procedures as described below to monitor the Member’s Grievance system and the expedited review of Grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22, CCR, Section 53858.

- A. Procedure to ensure timely acknowledgement, resolution and feedback to complainant. Provide oral notice of the resolution of an expedited review.
- B. Procedure to ensure a Member is given reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and a toll-free number with TTY/TDD and interpreter capability.
- C. Procedure for systematic aggregation and analysis of the Grievance data and use for Quality Improvement.
- D. Procedure to ensure that the Grievance submitted is reported to an appropriate level, i.e., medical issues versus health care delivery issues. To this end, Contractor shall ensure that any Grievance involving the Appeal of a denial based on lack of Medical Necessity, Appeal of a denial of a request for expedited resolution of a Grievance, or an Appeal that involves clinical issues shall be resolved by a health care professional with appropriate clinical expertise in treating the Member’s condition or disease.
- E. Procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Contractor’s Medical Director.
- F. Procedure to ensure that requirements of Title 22 CCR Section 51014.2 are met regarding services to Members during the Grievance process.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare

AUDIT PERIOD: October 1, 2017 through September 30, 2018

DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

4.1

GRIEVANCE SYSTEM

- G. Procedure to ensure that the person making the final decision for the proposed resolution of a Grievance has not participated in any prior decisions related to the Grievance and who are health care professionals with clinical expertise in treating a Member's condition or disease if any of the following apply:
- 1) A denial based on lack of medical necessity;
 - 2) A Grievance regarding denial of expedited resolutions of an Appeal; and any Grievance or Appeal involving clinical issues.
- H. Procedures to ensure that Members are given a reasonable opportunity to present, in writing or in person before the individual(s) resolving the Grievance, evidence, facts and law in support of their Grievance. In the case of a Grievance subject to expedited review, Contactor shall inform the Member of the limited time available to present evidence. Contractor shall also comply with 42 CFR 438.406(b)(3) concerning a Member's request to review records in connection with a Grievance.

PCCM Contract A.14.2

Grievance Log and Quarterly Grievance Report:

Contractor shall maintain, and have available for DHCS review, Grievance logs, including copies of Grievance logs of any sub-contracting entity delegated the responsibility to maintain and resolve Grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).

PCCM Contract A.14.3.A

ALL PLAN LETTER 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments:

The Medi-Cal managed care health plans shall ensure that the person making the final decision for the proposed resolution of a Grievance or Appeal has not participated in any prior decisions related to the Grievance or Appeal. Additionally, the decision-maker shall be a health care professional with clinical expertise in treating a beneficiary's condition or disease if any of the following apply: An Appeal of an Adverse Benefit Determination that is based on lack of medical necessity...A Grievance regarding denial of an expedited resolution of an Appeal...Any Grievance or Appeal involving clinical issues.

A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by the Medi-Cal managed care health plans to make an authorization decision. A complaint is the same as a Grievance.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare

AUDIT PERIOD: October 1, 2017 through September 30, 2018

DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

4.1

GRIEVANCE SYSTEM

Where the Medi-Cal managed care health plans is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance...An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other MCP processes...Medi-Cal managed care health plans shall not discourage the filing of Grievances. A beneficiary need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. If a beneficiary expressly declines to file a Grievance, the complaint shall still be categorized as a Grievance and not an inquiry.

Federal regulations require Medi-Cal managed care health plans to post nondiscrimination notice requirements and language assistance taglines in significant communications to beneficiaries. DHCS has thus created a sample "Nondiscrimination Notice" and "Language Assistance" taglines, which are available for Medi-Cal managed care health plan use. Medi-Cal managed care health plans may utilize the templates provided by DHCS, make modifications to the templates, or create new templates...These templates must be sent in conjunction with each of the following significant notices sent to beneficiaries: Notice of Action, Grievance acknowledgment letter, Appeal acknowledgment letter, Grievance resolution letter, and Notice of Appeal Resolution.

The Medi-Cal managed care health plan shall maintain a written record for each Grievance and Appeal received by the Medi-Cal managed care health plan. The record of each Grievance and Appeal shall be maintained in a log and include the following information: The date and time of receipt of the Grievance or Appeal...The name of the beneficiary filing the Grievance or Appeal...The representative recording the Grievance or Appeal...A description of the complaint or problem...A description of the action taken by the Medi-Cal managed care health plan or provider to investigate and resolve the Grievance or Appeal...The proposed resolution by the Medi-Cal managed care health plan or provider...The name of the Medi-Cal managed care health plan provider or staff responsible for resolving the Grievance or Appeal...The date of notification to the beneficiary of resolution.

References Cited:

Title 22 CCR Section 51014.2 – Medical Assistance Pending Fair Hearing Decision

Title 22 CCR Section 53858 – Member Grievance Procedures

Title 28 CCR Section 1300.68 – Grievance System

Title 28 CCR Section 1300.68.01 – Expedited Review of Grievances

42 CFR 438.400-406 – Statutory Definitions and Handling of Grievances and Appeals

42 CFR 438.420(a)(b) and (c) – Continuation of Benefits while the MCO or PIHP Appeal and the State Fair Hearing are Pending.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare

AUDIT PERIOD: October 1, 2017 through September 30, 2018

DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

SUMMARY OF FINDINGS:

4.1.1 Medical Quality of Care Grievances

The Contract states that the Plan shall maintain a full time Physician as Medical Director pursuant to Title 22, CCR, Section 53857 whose responsibilities shall include, but not be limited to, the following...resolving Grievances related to medical quality of care.

The All Plan Letter (APL) 17-006 states, that the Medi-Cal managed care health plan shall ensure that the person making the final decision for the proposed resolution of a Grievance or Appeal has not participated in any prior decisions related to the Grievance or Appeal. Additionally, the decision-maker shall be a health care professional with clinical expertise in treating a beneficiary's condition or disease if any of the following apply...any Grievance or Appeal involving clinical issues.

The Plan's Policy and Procedure RM 201.2, PHC California Member Grievance Process states "Grievances related to medical issues shall be referred to the Plan Medical Director or designee. All Grievances regarding medical quality of care, including but not limited to, an Appeal of a denial or an Appeal that involves clinical issues, are immediately referred to the Plan Medical Director or his or her designee for action. Any designee will be a licensed competent healthcare provider."

There was no documentation that the Plan's Medical Director, or a health care professional with clinical expertise in treating a beneficiary's condition or disease, was resolving Grievances related to medical quality of care. The Plan did not forward all Grievances related to medical quality of care to the medical director or designee for action, which indicates inconsistent or incomplete implementation of the Plan's policy. This is a systemic deficiency since all eight quality of care Grievances reported during the audit period were reviewed and only one case showed evidence of the medical director's involvement in the resolution of the Grievance by his actual entry on the Complaint, Grievance and Appeal Investigation Case Form.

The Plan staff were unaware that the Grievance files must contain direct evidence of the Medical Director's involvement in the resolution of the quality of care Grievances. The Plan did not have a process in place to ensure that all Grievances regarding medical quality of care were referred to the Plan Medical Director or his designee for resolution.

Without a health care professional with clinical expertise treating a beneficiary's condition or disease, the member will not have the clinical aspects of the Grievance properly resolved.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare

AUDIT PERIOD: October 1, 2017 through September 30, 2018

DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

4.1.2 Grievances Misclassified as Inquiries

The All Plan Letter (APL) 17-006 states that a Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination, also stated in Title 42, CFR Section 438.400(b)...A complaint is the same as a Grievance. Where the Medi-Cal managed care health plan is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance, as required by Title 28, CCR Sections 1300.68(a)(1) and (2)...An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Medi-Cal managed care health plans processes...Medi-Cal managed care health plans shall not discourage the filing of Grievances. A beneficiary need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. If a beneficiary expressly declines to file a Grievance, the complaint shall still be categorized as a Grievance and not an inquiry.

The Plan's Policy and Procedure RM 201, PHC California Member Grievance Process states a Grievance means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, and request for reconsideration or Appeal made by an enrollee or the enrollee's representative. Where the Plan is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.

The Plan was unable to distinguish between Grievances and inquiries, and did not record all Grievances received during the audit period. Among the five inquiry files reviewed, only one was actually an inquiry; three were exempt Grievances resolved in 24 hours and one was a standard Grievance for which the member did not receive acknowledgement and resolution letters.

The Plan did not follow the requirements of APL 17-006 to recognize an inquiry as a Grievance. The Plan's definition of an inquiry does not state that any expression of dissatisfaction shall be considered a Grievance. The Plan experienced a high amount of turnover in the Grievance department, which left gaps in oversight and knowledge within the department. New staff were not aware of the APL requirements and not trained to recognize a Grievance.

Inaccurate classification of Grievances as inquiries by the Plan hinders members' right to have their complaints resolved.

4.1.3 Nondiscrimination Notice and Language Assistance Taglines

The All Plan Letter (APL) 17-006 states that a "Nondiscrimination Notice" and "Language Assistance" tagline be sent in conjunction with the Grievance acknowledgment letter and the Grievance resolution letter.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare

AUDIT PERIOD: October 1, 2017 through September 30, 2018

DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

The Plan's Policy and Procedure RM 201.2, PHC California Member Grievance Process states that "all Plan staff shall address any cultural or linguistic barriers that a member might have in filing a Grievance and offer any assistance that might be required or requested."

The "Nondiscrimination Notice" and "Language Assistance" taglines were not supplied with the Grievance acknowledgment letters and the Grievance resolution letters during the audit period.

The Plan experienced a high amount of turnover in the Grievance Department. This turnover left gaps in oversight and knowledge within the department and new staff were not aware of the APL requirements.

Plan members were not informed about their right to nondiscrimination and language assistance.

4.1.4 Required Grievance Log Information

The All Plan Letter (APL) 17-006 states that the Medi-Cal Managed Care Plan shall maintain a written record for each Grievance and Appeal received by the Medi-Cal Managed Care Plan, as required by Title 22, CCR, Section 53858(e)(1) and Title 28, CCR, Section 1300.68(b)(5). The record of each Grievance and Appeal shall be maintained in a log and include the following: The date and time of receipt of the Grievance or Appeal, the name of the representative recording the Grievance or Appeal, the name of the managed care provider or staff responsible for resolving the Grievance or Appeal.

The Plan's Policy and Procedure RM 201.2, PHC California Member Grievance Process states that "a written record shall be established for each Grievance. Grievance documentation should capture all the elements required to be reported quarterly. These elements include: the date and time the Grievance is filed with the Plan or provider...The name of the Plan provider or staff member receiving the Grievance...The name of the Plan Provider or staff person responsible for resolving the Grievance or reference to source document listing staff involved in resolution of Grievance."

The Plan's Grievance log did not meet the standards set by APL 17-006, nor was it in compliance with the Plan's policy and procedures. The Plan's Grievance log was missing the time of receipt of the Grievance, the name of the representative recording the Grievance, and the name of the Medi-Cal Managed Care Plan provider or staff responsible for resolving the Grievance.

The Plan experienced a high amount of turnover in the Grievance Department. This turnover left gaps in oversight and knowledge within the department and new staff were not aware of the APL requirements.

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: AIDS Healthcare Foundation dba Positive Healthcare
AUDIT PERIOD: October 1, 2017 through September 30, 2018
DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

Information obtained from the Grievance log is analyzed and used for quality improvement efforts. If the Plan does not capture all the required elements in the Grievance log, the Plan will miss opportunities to improve the quality of care and services delivered to the members.

RECOMMENDATIONS:

4.1.1 Establish a process to ensure policy adherence so that all Grievances regarding medical quality of care are referred to the Medical Director or his designee and to ensure that his or her involvement in the resolution of the Grievance is properly documented in the Grievance files.

4.1.2 Develop and implement a process to ensure the proper classification and processing of Grievances.

4.1.3 Establish a process to ensure that the “Nondiscrimination Notice” and the “Language Assistance” taglines are verifiably sent with the Grievance acknowledgment letter and the Grievance resolution letter.

4.1.4 Establish a process to ensure policy adherence so that all required Grievance log information elements are included and used in the Grievance log.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare

AUDIT PERIOD: October 1, 2017 through September 30, 2018

DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

CATEGORY 5 – QUALITY MANAGEMENT

5.2

PROVIDER QUALIFICATIONS

Credentialing and Re-credentialing:

Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD, Credentialing and Recredentialing Policy Letter, MMCD Policy Letter 02-03. Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.
PCCM Contract A.4.13

Standards:

All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. All providers must have good standing in the Medicare and Medicaid/Medi-Cal programs and a valid National Provider Identifier (NPI) number. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.
PCCM Contract A.4.13.A

Medi-Cal Managed Care Provider Training:

Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly Contracted provider on active status. Contractor shall ensure that provider training includes information on all Member rights specified in Exhibit A, Attachment 13, Member Services, including the right to full disclosure of health care information and right to actively participate in health care decisions. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor or the State. Contractor shall develop and implement a process to provide information to providers and to train providers on a continuing basis regarding clinical protocols and evidenced-based practice guidelines for Seniors and Persons with Disabilities or chronic conditions.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare

AUDIT PERIOD: October 1, 2017 through September 30, 2018

DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

5.2

PROVIDER QUALIFICATIONS

This process shall include an educational program for providers regarding health needs specific to this populations that utilizes a variety of educational strategies, including but not limited to, posting information on websites as well as other methods of educational outreach to providers

PCCM Contract A.7.5

Delegated Credentialing:

Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6. Delegation of Quality Improvement Activities above.

PCCM Contract A.4.13.B

Disciplinary Actions:

Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider Appeal process.

PCCM Contract A.4.13.D

Medi-Cal and Medicare Provider Status:

The Contractor will verify that their subcontracted providers have not been terminated as Medi-Cal or Medicare providers or have not been placed on the Suspended and Ineligible Provider list. Terminated providers in either Medicare or Medi-Cal/Medicaid or on the Suspended and Ineligible Provider list, cannot participate in the Contractor's provider network.

PCCM Contract A.4.13.E

SUMMARY OF FINDINGS:

5.2.1 New Provider Training

The Contract states that the Plan shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all Federal and State statutes and regulations. Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly Contracted provider on active status.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare

AUDIT PERIOD: October 1, 2017 through September 30, 2018

DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

The Plan's Policy and Procedure PR 3.0, Provider Training and Education states that "the Plan shall provide orientations for new providers within ten (10) working days of active status. The Plan shall also maintain records of provider orientations, education and Provider Manual distributions. The Provider Relations Manager will monitor the compliance of new provider orientations on a monthly basis by submitting monthly reports that verify whether provider trainings are being conducted within the required timeframes."

In response to the prior year finding, the Plan's corrective action measures to update the Provider Orientation Summary, implement the Provider Orientation Checklist, and implement the Provider Orientation Training Log to enhance documentation of the provider orientations were ineffective and did not correct the prior year finding.

The Plan did not meet the requirement to provide training within ten (10) working days after the Plan places a newly Contracted provider on active status. The verification study revealed that there was no supporting documentation that training had been completed as required by the Contract. The Plan's New Provider Orientation Log indicated that four out of seven in the verification samples had not completed the orientation within the ten (10) working day requirement. The verification study also disclosed that the reported dates found in the Provider Orientation Summary, Provider Orientation Checklist and the Provider Orientation Training Log were inconsistent.

According to Plan, existing Provider Relations staff were not aware of the specific Contract references associated with the Plan's Provider Orientation Training standard, and the staff were conducting new provider orientations and trainings outside the required timeline. Some new providers received the orientation training a few days to several months after being placed on active status.

When new providers do not receive the required new provider training, it may affect the delivery of service to the members.

This is a repeat finding.

5.2.2 New Provider Training on Member Rights

The Contract states that the Plan shall ensure that provider training includes information on all Member Rights specified in Exhibit A, Attachment 13, Member Services, including the right to full disclosure of health care information and the right to actively participate in health care decisions.

The Plan's Policy and Procedure PR 3.0, Provider Training and education states that "the Provider Relations Department will distribute a Provider Manual to all new providers within 30 working days upon execution of the Contract with the Health Plan, and the Provider relations

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: AIDS Healthcare Foundation dba Positive Healthcare
AUDIT PERIOD: October 1, 2017 through September 30, 2018
DATE OF ONSITE AUDIT: January 22, 2019 through January 31, 2019

Representatives will maintain a record in the provider file for all Provider Manuals distributed. The Provider Manual contains a section on Member Rights and Responsibilities.” The verification study disclosed that the Provider Orientation Summary did not include Member Rights as a topic of discussion. Furthermore, the orientation materials did not include Member Rights in any of the orientation materials. The Plan’s staff was informed that the only place where Member Rights was found was in the Provider Manual. The Plan’s policy and procedure states that the Provider Manual will be distributed to all new providers within thirty (30) working days upon execution of the Contract with the Health Plan. The Plan runs the risk that the 10 working day requirement to provide the training will not be met.

The Plan experienced a high amount of turnover in Provider Relations. This turnover left gaps in leadership, oversight, and knowledge within the department. The Plan acknowledged that they need to make improvements in the Provider Training process. The Plan has hired a National Director of Provider Relations, who intends to make improvements in the Provider Training process.

If providers are unaware of the Members Rights and Responsibilities, members may not receive contractually required services.

RECOMMENDATIONS:

5.2.1 Develop and implement a process so that new providers receive training within ten (10) working days after being placed on active status.

5.2.2 Update the policy and procedure and ensure that Member Rights are included in new provider training as required by the Contract.